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ABSTRACT

The program was set up to involve, on a continuing basis, the significant other of frequently-readmitted hospitalized psychiatric VA patients. The couples identified their characteristic strengths, and their maladaptive ways of functioning, and were expected to make use of alternative ways of behaving which were recommended by the staff. A day-long training workshop was held for group members and significant others which emphasized communication, decision making, feedback and individual styles of problem solving. Certain in-hospital events which called for group cohesion and/or specific behavior change were enacted. After release, 39 couples who completed the program remained in contact via telephone for six months. The results of a rating system used are strongly suggestive that the level of the patient's adjustment and the level of the family's adjustment, as perceived by the patient and the significant other for the first six months after he left the hospital, were significantly higher than the level of adjustment which existed before the veteran entered the hospital. Interesting discoveries were made regarding utilization of a problem and solution worksheet approach, the utilization of phone calls as a means of keeping in contact with patients for follow-up ratings, the use of a pragmatic behaviorally-oriented approach rather than an insight and/or dynamic type orientation, and the importance of requiring couples to report how they dealt with specific problems which occurred while the veteran was on pass from the hospital. (Author/LFB)

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Reducing Maladaptive Family Interaction by Involving Significant Others of Hospitalized Psychiatric Patients

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Reducing Maladaptive Family Interaction

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Abstract

The program was set up to involve , on a continuing basis, the significant other of hospitalized psychiatric VA patients. The approach was a pragmatic one. The couples identified their characteristic maladaptive ways of functioning. The couples were expected to make use of alternative ways of behaving which were recommended by the staff. Feedback was obtained regarding outcome of the use of the alternatives. We stayed in contact, by means of phone calls, with 39 couples who completed the program for six months after they left the hospital. The results of a rating system used are strongly suggestive that the level of the patient's adjustment and the level of the family's adjustment, as perceived by the patient and the significant other for the first six months after he left the hospital, were significantly higher than the level of adjustment which existed before the veteran entered the hospital. Interesting discoveries were made regarding utilization of a problem and solution worksheet approach, the utilization of phone calls as a means of keeping in contact with patients for follow-up ratings, the use of a pragmatic behaviorally-oriented approach rather than an insight and/or dynamic type orientation, and the importance of requiring couples to report how they dealt with specific problems which occurred while the veteran was on pass from the hospital.

Reducing Maladaptive Family Interaction by
Involving Significant Others of Hospitalized Psychiatric Patients

This paper deals with the development and results of a treatment program specifically designed for frequently returning patients. After it was determined that sufficient staff interest existed, meetings were held for eight weeks to develop an operational program. Meetings were attended by two or three nursing assistants, one registered nurse, and the author. We dealt with the philosophy of the program, its day to day operating rules and policies, expectations regarding the patients' behavior, techniques and therapeutic modalities, etc. We viewed entering the hospital to be a means mutually, though not necessarily

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Acknowledgements:

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explicitly, agreed upon by the patient and his family, to deal with difficulties which arose in the community. We held that patients and their families are capable of making changes in the ways they behave toward each other and thereby have alternatives available to them which would enable them to remain in the community. We called the program the Family Involvement Program (FIP). Our emphasis was to be on "how" and "what people do" rather than an approach emphasizing "why." The program was to be pragmatic, non-intellectually oriented, and task-directed in its approach.

The initial criteria for admission were as follows: (1) a returning patient whose length of stay in the community was less than 365 days; (2) a returnee, single or married, would be expected to have some significant person in the community to become involved in his treatment; (3) a patient with a sociopathic diagnosis, mental retardation, or suffering from brain damage to the extent that it precluded adequate participation in the program, would be excluded. If a patient fulfilled the admission criteria for the program but did not wish to participate, or if the significant other was not willing to commit himself or herself to involvement in the program, the patient would be discharged from the hospital. Being re-admitted without being in the program would constitute a repetition of his previous hospitalization and once again reinforce the use of hospitalization

as a means of avoiding out-of-the-hospital problems. Shortly after the program started it became apparent that there were patients who did not meet the criteria for admission who might profit from what the program was offering. Consequently, any patient, regardless of diagnosis, judged by the admitting team as one who might profit, was considered as a possible candidate.

The family was viewed as a treatment resource rather than merely a group of people to whom a patient returns after he leaves the hospital. Therefore, strong efforts were made to involve the significant other in the treatment program by urging them to participate in designating the solving of what they and the patient mutually agreed upon as problems. To this end, the significant other was required to come to the hospital shortly after a patient had been admitted in order to emphasize the importance of the significant other in the program.

A minimum of three visits were required of the significant other. The first, for participation in an interview; the second, usually a week later, to work with the staff and patient in developing a Problem and Solution Worksheet, described later in this paper; and the third, to attend a workshop, also described later.

Each tentative candidate for the program and their significant other were interviewed by available staff members within a

week after admission to the hospital. However, due to limitation in nursing staff time, the interviews were done primarily by the psychologist and social work associate assigned to the program. The interview is a modification of the one used at Central Louisiana State Hospital in their program for multiple readmission psychiatric patients.

With experience, the interview became a preparatory stage for the Problem and Solution Worksheet phase. Following the interview, the candidate and significant other were each given blank forms of the Problem and Solution Worksheet and asked to develop a preliminary worksheet themselves. This would be used as a guideline to work from in developing the final worksheet with the staff and FIP group. An outcome of this procedure was that the couple was working together from the beginning to identify maladaptive behaviors.

The final Problem and Solution Worksheet (Appendix B) was developed with the couple during one of the afternoon group meetings. The goal of the Problem and Solution Worksheet was to enable the couple to (a) clearly objectify those qualities and characteristics of the patient, significant other, and the couple as a pair, which they felt were strengths; (b) those behaviors which the patient, significant other, or the pair in consort carry out which were seen an maladaptive; (c) discover highly

specific alternative ways of handling situations to which identified maladaptive behaviors were a usual response. These fell under the respective headings of personal strengths, maladaptive behaviors, and alternative behaviors. Having the significant other present and involved in developing the worksheet contributed to their involvement in the program.

The third required visit by the significant other was attendance at a day long training lab type workshop held for group members and their significant others. The lab exercise emphasized communication, decision making, feedback, and individual styles of problem solving. The labs were held approximately every six weeks so that all couples in the program participated.

Certain in-hospital events were occurring simultaneously with the above described required contacts between staff and patients and significant others. Coincident with the first interview the patient became involved in the group of patients in the program. A work detail of two to four hours a day was assigned. The group had responsibility for the upkeep of the dorm where all program patients lived. In general, the message was conveyed that patients were expected to work together, helping each other in any way possible. The groups usually became cohesive and a strong espirit de corps emerged.

The group met each morning in order to discuss issues that were relevant to the program as a whole as well as individual issues that might come up regarding behavior or concerns of members. Information of concern to the staff regarding a patient's behavior was sent to the group via a printed note form, i.e. Mr. Black had not attended his work detail Tuesday. It was the group's job to discuss these issues reported in the notes, make a decision regarding the matter, and make a written reply on the note form which was then returned to the staff. Special requests approved by the group were sent to the staff via the note system for consideration, i.e. special pass requests.

Three or four days a week, depending upon the needs of the group, afternoon group meetings with staff were held. These meetings were unstructured. Often relaxation training was carried out, occasionally individual Gestalt work was done, structured feedback procedures were utilized, and at other times specific behaviors were identified which we felt a patient should either increase or extinguish. Regarding the latter, an individualized program would be set up using a card which the member would carry and have signed by fellow group members when he carried out the behavior prescription indicated on the card, i.e. share with someone how you are feeling. Also, as mentioned

earlier, group meetings were used for development of worksheets so that all group members were able to have input.

One afternoon meeting each week, usually Monday, was devoted to dealing with what occurred during the weekend passes. Weekend passes or other passes were not viewed in the traditional sense as time out of the hospital. They were considered as trial runs, the purpose of which was to try new behavior in the home setting. "Pass" procedures involved the patient deciding what maladaptive behaviors on the worksheet he wishes to work on during the "pass" and recording his choice in writing. Initially the social worker then contacted the family informing them of the patient's intention to have a pass and alerting them to what he wished to work on. The patient would take home the form on which the behaviors-to-be-worked-on were specified. It was the patient's and significant other's responsibility to make written comments regarding the outcome of the couple's use of the appropriate alternative behavior as indicated on the worksheet. The patient would return the record sheet to the staff after the weekend. During the Monday meeting, the feedback would be shared with the group and problems which arose would be discussed. Frequently the significant other was present.

When it seemed feasible, we would give men longer trial runs, i.e. a week or two. During the leave the social worker was

contacted by phone at designated times so as to receive feedback regarding how the couples were dealing with the problem areas indicated on their worksheet. The few times we used this approach the calls were regularly made by the families.

Just prior to discharge, a "behavioral fingerprint" was developed for each patient to enable him to receive a clear picture of how he appeared to others. To develop a "behavioral fingerprint" a five year reunion of the group is imagined. The person whose "fingerprint" is being done is supposedly not present. The other members of the group are to try to describe, as comprehensively as possible, how they would remember the "missing individual." This technique proved quite effective.

We developed a post-hospital follow-up procedure which was modeled after the telephone follow-up used at the Louisiana State Hospital (Deiker, et al, 1971). The patient would be called once a week for the first month he was out of the hospital, once every two weeks for the next two months, and once a month for three months, for a total of six months. Also, an arrangement was made for those patientswho come to the hospital for their medicines to meet with a staff person and work out any difficulties that might have arisen.

During the phone calls, the significant other and the patient were asked to rate the patient's adjustment on a 7-point scale. They were told that a rating of 4 would reflect that the

patient's adjustment was at the same level as just before he came into the hospital, a rating of 1 reflected his adjustment was much worse than just before he came into the hospital, and a rating of 7 reflected his adjustment was much better than just before he came into the hospital. Through experience we found it possible to ask the significant other and the patient to also rate the overall family level of adjustment on the same scale.

In summary, we were able to obtain post-hospital ratings by patient and significant other of the patient's level of adjustment and the family's level of adjustment. The outcome of these ratings is presented in the results section. The measure satisfied two important principles of program evaluation: judgment of treatment outcome based on community functioning, and evaluation of post-hospital functioning by the consumers of hospital service (Ellsworth, 1970). The question asked was compatible with an item found by Ellsworth (1970) to be reliable and sensitive to outcome differences between programs, differences which had been revealed by the full scale to which the item originally belonged.

Results

At the time of writing, the program has been in effect 27 months, a total of 78 couples having been admitted. Nine patients

did not complete the program. Of these nine, one left the program before it was over due to his father's becoming terminally ill. A second patient left the program Against Medical Advice, but did return to participate in the program workshop and we were able to follow him by phone in the community. Of the remaining seven patients who had not completed the program, two were discharged due to drinking, and five patients did not return from pass. Of the five who did not return from pass, all left within three weeks of being admitted to the program but had developed a worksheet with their significant other.

With regard to patients who had completed the program, we were not able to follow four couples due to their separating shortly after leaving the hospital. We were not able to reach five other couples by phone, but of these five, we have encouraging narrative data for two couples regarding their adjustment.

Further, there were three couples who had finished the program whom we were able to follow for approximately three months and one couple for one month, but due to their moving and/or our not being able to keep in contact were were not able to follow for the complete six month period.

In addition, one man was placed in jail within two weeks of having left the program and another man died within 3-1/2 months

after leaving the hospital. Four men returned to the hospital in less than six months after discharge. All four men returned within six weeks of leaving the program.

We were able to follow the remaining 39 couples for six months after they left the hospital. Currently 13 couples are still being followed in the community.

The range of post-hospital community stay was 183 to 750 days for the 39 subjects whom it was possible to follow for six months by telephone. Post-hospital length of stay in the community is shown on Table 1.

Insert Table 1 about here

There were 24 men who had histories of prior hospitalizations at Roseburg VAH. Comparison was made of pre vs. post-FIP length of stay in the community. One man returned after 29 days in the community whose pre-FIP length of community stay was 13 days. A second man who had been readmitted after leaving the FIP stayed in the community 183 days vs. the 135 days he had stayed in the community prior to entering the FIP. A third man whose pre-FIP length of community stay was 1118 days returned after being in the community 328 days.

Among the other 21 cases were 15 for whom it was possible for their post-FIP community stay to surpass the pre-FIP length of stay and such was the case. The pre-FIP length of community stay of the remaining six patients was of longer duration than the period from when they left the FIP and the time when this paper was written.

Recidivism was examined for 39 patients whom we were able to stay in contact with by phone for six months after leaving the hospital, as well as four patients who returned to the hospital very shortly after being discharged. Of these four patients, their respective number of days out of the hospital were 13, 28, 36, and 42 days. Looking at the data at 180 days after discharge there were 28 patients who could have been out at least six months. Their lengths of stay were reported above.

Looking at the data at 365 days after discharge there were 27 patients who could have been out at least one year since their discharge from the program. Six of these 27 returned in less than 365 days. These six consisted of the four who had returned shortly after leaving the program and two others who returned after being out 183 and 192 days respectively. The rate of recidivism at six months was 14% and at one year 22%.

Table 1 summarizes the results of the ratings of adjustment of the patient and family of the 39 couples we have been able to follow by phone for six months after leaving the hospital.

Insert Table 2 about here

The data was subject to analysis by Student's T to determine if there was a significant difference between each mean and a rating of four. Four, the mid-point of the adjustment scale, was chosen earlier to represent the level of adjustment of patient and family just prior to the patient's entering the hospital. The four means presented are the patient's rating of his adjustment, the patient's rating of the family's adjustment, the significant other's rating of the patient's adjustment, and the significant other's rating of the family's adjustment. The results show significance at .005 level for all four means with 38 degrees of freedom and one tailed T of 2.57 or more.

The correlation between the significant other's rating of patient's post hospital level of adjustment, and the patient's rating of his post hospital level of adjustment was .86. The correlation between the significant other's rating of the family's post hospital level of adjustment, and the patient's rating of the family's post hospital level of adjustment was .74. Both correlations are significant at .005 with 37 degrees of freedom. The correlation between the significant other's rating of the patient's post hospital level of adjustment and the

significant other's rating of the family's post hospital level of adjustment is .62 which is significant at .005 with 37 degrees of freedom. A correlation of r = .34 was found between the patient's rating of his post hospital level of adjustment and his rating of the family's post hospital level of adjustment.[1]

Discussion of Results

The recidivism rate at six months (14%) and one year (22%) compared favorably with those suggested by Anthony et al (1972) as base rate data for recidivism at those intervals. These results suggest that for the patients we were able to keep in contact with for six months by phone, length of stay in the community clearly exceeded what could have been expected to follow their involvement in a traditional psychiatric program. 'Traditional' is defined by Anthony et al (1972) as being a hospital regime composed of drug treatment, and possibly some form of group and/or individual therapy.

The patients come from within the catchment area which Roseburg VAH serves. This lends support to the validity of our recidivism data in that it is likely that patients who had been through the program would, if they had been rehospitalized, have returned to Roseburg. Had such returns occurred we would have been informed.

Where comparison could be made between pre- and post-FIP length of community stay, in all but one case the post-FIP length

of stay was of longer duration. This suggests that the FIP experience was more beneficial than their previous hospital experiences.

The average rating of the patient and the significant other of the patient's level of adjustment and the family's level of adjustment for the first six months after he had left the hospital was judged significantly higher than the level of adjustment, described in retrospect, existing just before the patient entered the hospital.

The correlation of .62 between the significant other's view of the patient's level of adjustment and the level of family adjustment may indicate that the significant other's view of positive changes in the family reflects changes independent of changes seen in the patient. That is, the improvement seen in the family may not be solely a function of the patient's change as perceived by the significant other.

Thus, the analysis of the data suggests that both patients and significant others judged the patients' and families' adjustment to be significantly better after the program than before entry into the program. The adjustment of the family as a whole appeared to have improved.

Discoveries

A number of discoveries emerged as time passed:

1. Within a relatively short time after the program started, the skepticism of non-FIP staff became almost non-existent.

2. Significant others came as far as 275 miles for the necessary meetings. Apparently, when the family receives the impression that they are really needed as part of the treatment program, they are willing to go to considerable effort to work with the staff. Thus, in contrast to pre-program apprehension, significant others were willing to come to the hospital from long distances.

3. There was an initial skepticism by couples with regard to the Problem and Solution worksheet. The approach was inconsistent with their expectations of what "treatment" is supposed to be. The idea of the couples themselves identifying their own maladaptive behaviors and the fact that we were dealing with maladaptive behaviors, rather than "problems" was not consistent with traditional expectations. The skepticism diminished when the couple actually began to work together in the development of a preliminary worksheet. A key requirement in developing a worksheet was that only items which were mutually agreeable to both members of the couple were acceptable. Thus, early in the program the couples were forced to not only identify their maladaptive behaviors, but to work together. Support for the program in general, and the worksheet approach in particular, came from two

additional sources. First, from patients who had been in the program for a while and had begun to make some changes. Reassuring comments to the effect that "we had problems like that when we came into the program and we have been able to make some changes" were not unusual. Secondly, skepticism was diminished due to experiences the couple had, usually on the first few passes, that having identified their maladaptive behaviors via the worksheet it was then possible to behave differently toward each other. For some couples this was a revelation. It soon became apparent that it didn't matter which maladaptive behavior was chosen to be worked on during the initial passes. The experience of change in the particular maladaptive behavior initially chosen to work on generalized to other areas on the worksheet. Couples reported that other problem areas on the worksheet just "seemed to fall into line," having found that change was possible. In those cases where the worksheet was somewhat superficial, the generalization extended to those maladaptive ways of relating which were important to the couple but had not been designated in their initial development of the worksheet.

By offering alternative means of dealing with maladaptive behavior we made tools available to families. The tangibleness of alternatives of the worksheet enable each member of a couple to make demands on the other to behave in specific ways. We were

legitimizing demands they could make on each other to change, i.e. "the worksheet says we should do such and such."

4. It is beneficial to use a pragmatic, behaviorally oriented approach as a means to enable patients and significant others to identify and then make changes in how they behave toward each other. Insight and understanding of dynamics were not a necessary prerequisite to identifying what needed to be dealt with and in making subsequent changes. We feel that by avoiding retrogressing into "why" types of questions, and focusing on "what and "how" people behave toward each other, we have been able to cause change and thereby generate awareness.

5. The use of the weekly feedback session was found to be of considerable importance. It gave strong support to couples who were making use of the alternative behaviors on the worksheet. Sharing the changes they had made with the rest of the group was often very rewarding. The meetings were therapeutic in that the staff and patients had opportunity to point out to couples when they were not making use of the recommended alternative behaviors and were resorting to maladaptive behaviors they had used previously.

We found that when we emphasized the importance of comprehensive written feedback regarding the couples' behavior on the

"pass" the quality of the feedback became richer and in most cases the behavior of the couple reflected more efforts to change. Frequently the significant other was present during the meeting which made it possible for a couple, with the help of staff, to deal with their pass experiences. Some significant others traveled over a hundred miles to be present at the weekly meetings. When more than one significant other was present, sharing took place among all of them. This meeting became the high point of the week for patients, significant others, and staff.

6. As the program developed we came to the realization that patients often were extremely concerned with behaving in accordance with prescriptions they had been given defining how one should behave in order to be a "man." Due to this an additional feature was developed for a few groups. It was the clarification of expectations that men felt are put upon them because they are males, as they are growing up. We held a special session for the patients and their wives during which we helped both the patients and their wives clarify what the expectations are that are usually put on men because they are males. We then used a rating procedure for the men to rate the extent to which they were pleased with these expectations. We also asked the wives to rate the extent to which they were pleased with the men carrying out these expectations. The results suggested that neither the men nor their

wives were supportive of a number of the expectations that had strong macho features. The wives supported their husbands allowing themselves to be more gentle and more accepting of their feelings, and the men seemed to be saying that they would like to be as their wives were indicating they preferred them to be.

7. A hypothesis regarding the couples who separated soon after they left the program was that they made their decision to separate after they realized they were not willing to give up their maladaptive behaviors. In a sense, the FIP could be viewed as having been helpful in forcing them to come to grips with the issue of their being married.

8. Regarding the use of phone calls as a post hospital follow-up method, we found them to serve a number of purposes. First, the phone calls enabled us to stay in contact with the families so that the program did not stop with discharge. Maintaining contact in and of itself appears to have been beneficial. Those who received the calls saw the treatment staff as still interested in them. Characteristically, the significant other expressed gratefulness for the contact itself and concern expressed by the staff. Second, by keeping in contact we were able to support the expectation that the ex-patient and family would not resume use of the maladaptive approaches to problem solving that had been characteristic prior to the family being involved in the program. In a sense we were reminders of agreements made with us

and with each other regarding utilization of alternatives in place of their maladaptive behaviors. Third, by use of the phone calls we have been able to prevent rehospitalization. Phone calls used as the occasion to make an evaluation of the adjustment of the ex-patient and his family led, in some instances, to the patient and his family seeing the treatment staff for problem solving conferences, which prevented rehospitalization. The fourth use of the phone calls was that they enabled us to gather research information regarding the effectiveness of the treatment program by asking for ratings of adjustment. Fifth, the phone calls seem to be economical in terms of actual time used, number of staff involved, and in the sense of preventing rehospitalization. Sixth, the phone call approach discourages patients from using community resources as means to support pre-hospitalization behavior or support for seeking rehospitalization. Finally, an extremely beneficial advantage of the phone calls is that they enable the staff to be kept up to date on the family's progress in the community. This often enabled us to feel good about how families were progressing. In a sense, the family was still with us though out of the hospital. We were able to share with patients who were still in the hospital the impressions and comments of patients who were out of the hospital so as to prepare them for their follow-up.

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Footnote

1. The results of the ratings by patients and significant others are presented with an awareness of the potential problems in using an arbitrary rating of 4 to represent pre-hospital level of adjustment against which post-hospital level of adjustment was compared rather than comparing post-hospital level of adjustment with a pre-treatment rating made at the time of admission. With recognition of the weaknesses of design, the results of the ratings are being presented due to their direction and magnitude.

Table 1

Days in the Community	Number of Patients
101 to 200	4
201 to 300	5
301 to 400	7
401 to 500	4
501 to 600	7
601 to 700	7
701 to 800	5

Table 2

Post Hospital Mean Ratings of Adjustment of Ex-patients and Their Families as Rated by the Ex-patients and Their Significant Other (wife or mother) for the Six Months After Being Discharged

SS	Patient's rating of his adjustment	Patient's ratings of family's adjustment	Sig. other's rating of patient's adjustment	Sig. other's rating of family's adjustment
1	6.000	4.000	5.937	4.000
2	4.000	6.000	4.250	4.850
3	5.000	5.125	4.928	4.357
4	6.100	5.600	6.222	6.111
5	5.562	5.357	4.650	5.500
6	6.863	6.863	6.681	6.863
7	3.722	6.889	5.056	6.000
8	6.750	4.250	6.150	4.300
9	6.555	6.714	6.571	6.571
10	5.937	6.071	6.143	6.071
11	4.200	5.600	4.187	4.062
12	5.687	5.875	6.050	6.100
13	4.318	5.050	5.909	5.850
14	4.200	4.950	5.500	5.500

				Reducint Maladaptive 27
15	5.611	5.438	6.200	6.000
16	3.800	4.778	3.454	5.000
17	6.273	6.545	6.364	6.545
18	5.438	4.917	6.062	5.583
19	2.437	3.722	2.250	3.722
20	7.000	7.000	7.000	7.000
21	5.100	6.187	5.550	5.500
22	2.625	6.600	2.312	6.538
23	5.071	5.786	5.100	5.150
24	6.000	6.000	6.083	6.000
25	7.000	7.000	6.928	6.714
26	6.333	6.000	6.833	6.833
27	5.944	6.444	6.187	6.437
28	5.833	6.111	6.182	6.273
29	6.357	5.929	5.450	5.700
30	4.000	4.850	5.500	5.500
31	4.571	5.071	4.667	5.111
32	5.286	5.643	5.091	5.409
33	5.444	5.722	5.000	5.750
34	3.143	5.714	3.350	3.850
35	4.750	5.500	3.500	4.312
36	5.750	6.000	5.137	4.812
37	4.500	5.222	4.444	5.357
38	5.389	6.167	4.750	6.150

39	7.000	6.909	7.000	7.000
MEAN	5.270	5.732	5.351	5.601

Appendix A

Problem and Solution Worksheet

Mr. and Mrs. A were a couple in their late forties. They had been married for approximately twenty years and had four children, all of whom were out of the home. The couple basically had an unsatisfactory marriage in that they never did get along well. He had been quite successful in a variety of jobs. She was successful at her profession which was one of the health care professions. He came to the hospital due to extreme depression and uncertainty as to whether or not the marriage should be continued

Personal Strengths	Problems: Maladjustive Behaviors	Solution:Adaptive Behaviors
1. Mrs. A. is faithful and reliable	1. Disagreements are responded to either by unilateral decision, impasses, or the other party blowing up.	1.a. One person identifying that a disagreement is occurring and call time out.
2. Mrs. A. is a good business manager.		1.b. Both stay present for three minutes.
3. Mrs. A keeps the house comfortable to live in.		1.c. The person who did not identify disagreement announces three minutes is up.
4. Mr. and Mrs. A have interests in common.		1.d. Start to talk taking turns
		1.e. Listen honestly (upon request summarize other's views).

		Reducing Maladaptive
5. Mr. and Mrs. A are well groomed and clean.		1.f. Continue till mutually agreeable to stop.
6. Mr. and Mrs. A are helpful to and supportive of their adult children's needs		1.g. Stay away from "why" questions unless it is honestly for information.
		1.h. Keep a box score re: use of new method (above) vs. use of old way.
7. Mr. and Mrs. A. are good at their jobs and are steady workers.	2. In response to job tension and/or depression Mr. A drinks	2.a. Mr. A drinks one beer before or at supper.
8. Mr. A is kind and gentle to people.		2.b. Mr. A keep a box score of occasions where he is tempted to use feeling badly as justification to drink but doesn't vs. when he does.
9. Mr. and Mrs. A come from similar backgrounds		2.c.1. If Mr. A feels badly he should express that he does and allow self 5 minutes alone, and then return to involvement.

	2.c.2. Feeling uncomfortable is not to be used as justification for "stopping,""withdrawal," etc.
3. Mrs. A. "fault finds" too much and responds to his not doing what needs to be done by trying to get him to do it: i.e. Mrs. A makes it her responsibility for Mr. A to do the job.	3.a. Mr. A teach wife relaxation training and use of calm scene. 3.b. Mrs. A use "calm scene" in response to situations that she usually responds to by becoming upset. 3.c. Mr. A will do what needs to be done i.e. around the house. 3.d. Mrs. A will make an effort to stop taking responsibility for Mr. A doing what he should. 3.e. Mrs. A keep a box score of occasions when she was tempted to take a responsibility for Mr. A but did not vs. when she did.

	3.f. Each express appreciation of the other when the other makes changes i.e. Mr. A does what he should and/or Mrs. A doesn't bug him or take responsibility for his doing things.
4. No sex relations	4.a. Possible Mental Hygiene Clinic referral upon discharge 4.b. If couple wishes, see Dr. Mabel during stay in FIP.
5. Reciprocal irritating habits: i.e. Mrs. A talks loudly and Mr. A has clearing of throat and/or a tic.	5.a. Mrs. A speak more quietly 5.b. Mr. A should give Mrs. A feedback when she is speaking more quietly. 5.c. Same type of positive feedback from Mrs. A in response to Mr. A limiting the frequency of his tic, throat clearing, etc.

6. Don't talk to each other; tend to not listen, each says what they want to say but not necessarily directly responding to what the other has said.	6.a. Identify when not "talking to each other" or listening to each other is happening. 6.b. Use procedure #1.

Appendix B

Problem and Solution Worksheet

Mr. and Mrs. C were both in their late fifties. Mr. C had been suffering from idiopathic epilepsy for the past twenty years. Prior to his coming to the hospital, he was very irritable, critical and argumentative with his wife, was having some trouble with getting his medicine regulated, and his wife was afraid of him.

Personal Strengths	Problems: Maladjustive Behaviors	Solution: Adaptive Behaviors
1. As a couple, Mr. and Mrs. C enjoy having each others company and enjoy having each other around.	1. When Mr. C does not understand what is going on or doesn't feel involved, he hums, whistles, goes into private conversation, ignoring people.	1.a. Ask for clarification if you don't understand and if confused mention being confused and then continue the interaction. 1.b. Make efforts to socialize on ward when feeling uninvolved.
2. Usually talk things out to come to some conclusions.	2. Mr. C uses grocery store carts as scooters.	2. Mrs. C will tell Mr. C how much she appreciates his not using the scooter.
3. If Mr. C lets himself, he can be a very nice person to be around.		

4. Mr. C has the capacity to be cooperative and help around the house.	3. Mr. C too often speaks of his seizures.	3.a. Men in group and wife not listen to seizure talk. 3.b. Tell him when he has not talked about seizures.
5. Mr. C takes good care of the house and Mrs. C also; she is a generous hostess.	4. Mr. C doesn't express concern for Mrs. C, i.e. does not acknowledge Mrs. C is present or what she does that he likes. Mr. C takes these things for granted.	4. Mr. C tell wife when she does something he likes; also greet her when he sees her during the day.
6. Have been married for 35 years and it has been a good marriage.	5. Mrs. C has little opportunity to be unconcerned regarding Mr. C.	5. Mr. C wants Mrs. C to go someplace alone, i.e. shopping when she feels the need.
	6. Mr. C makes frequent references to the fact that she has to drive (and he can't).	6. Same as 3.a. and 3.b.

7. Mr. C doesn't ask wife to do things she may enjoy, i.e. playing cribbage or going places.	7.a. Mr. C make reasonable suggestions, i.e. places to go. 7.b. Mrs. C should tell Mr. C that she would like to go somewhere and ask if he would like to go along.
8. Mr. C doesn't give clear answers, i.e. "what the hell for?"	8. Give straight answer, don't answer a question with a question.

Appendix C

Problem and Solution Worksheet

Mr. and Mrs. D have been married for approximately six years. Mr. D had not done well since leaving the service, being unable to hold jobs. He had experienced periods of psychotic depression and at the time he came into the hospital seemed unable to be productive. His wife was at the point of talking in terms of his being productive as he had been prior to entering the service or their separating. They had two young children.

Personal Strengths	Problems: Maladjustive Behaviors	Solution: Adaptive Behaviors
1. Mr. D gets along well with children.	1. In response to feeling upset Mr. D becomes "silent" or irritable verbally. Often in response to disagreement with wife.	1. When Mr. D feels self feeling upset: a. Accept that he feels upset. b. Let wife or other person or group member know that he is feeling upset and will want 5 minutes to be by himself. c. Identify to self what he is feeling.
2. He is prompt.		
3. He is neat.		
4. Mr. D is polite.		
5. Mr. and Mrs. D are faithful to each other and their church.		

6. Mrs. D cares for children both physically and psychologically.

7. Mrs. D puts children and husband first.

8. As a couple Mr. and Mrs. D love each other.

2. In response to experience of not being able to cope, Mr. D sings, goes for a walk or makes noises.

3. Mrs. D handles her feelings of disappointment and anger by holding

d. After 5 minutes let wife (or other) know what he was responding to by being upset.

e. Other person listen but no prolonged discussion.

2. In response to feeling can't cope.

a. Stop.

b. Take 15 minutes at least as an intermission.

c. Come back to whatever you were having trouble coping with and continue.

d. Share with wife that you have dealt with the problem.

3.a. Use # 1.

3.b. If by self, clarify how you feel, accept it

them in, crying or telling Mr. D when she feels her back is up against the wall.	and let "other" self be compassionate toward you.
4. Mr. and Mrs. D sometimes talk past each other.	4.a. Identify that talking past each other is occurring. 4.b. Stay present and silent for 3 minutes. 4.c. At end of 3 minutes Mr. D announces time is up. 4.d. Start talking taking turns. 4.e. Listen honestly. 4.f. Continue till mutually agreed upon to stop.
5. Mrs. D responds to feeling badly about self by crying. Puts down self.	5.a. Use # 3. 5.b. Use score card to keep record if giving a clear answer vs. an unclear one.

	5.c. Mrs. D make a commitment to work on a "project" which upon its completion she would feel good about during the program.
6. At times Mrs. D yells at kids.	6.a. Check out with children each evening to see if you yelled too much at them. 6.b. Use timer or clock to regulate how long children stay in room.
7. Mr. D needs assistance in vocational training.	7. See Dr. Mabel if need assistance.
8. Mr. and Mrs. D don't get away alone as often as they could.	8. Mr. and Mrs. D take turns suggesting that they spend time alone. Mrs. D make the first request.